MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

COMPANION GUIDE FOR THE HIPAA 837 DENTAL ENCOUNTER ADDENDA VERSION 4010A1

DENTAL HEALTH PLANS

August 12, 2004

Michigan Department of Community Health

MDCH

MSA MEDICAL SERVICES ADMINISTRATION

This document is intended as a companion to the **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Dental Claim Addenda, ASC X12N 837 (004010X097A1)**, dated October 2002 and the **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Dental Claim, ASC X12N 837 (004010X097)**, dated May 2000. It contains data clarifications authorized in the Final Rule by the Department of Health and Human Services (HHS) on September 17, 2001. The clarifications include:

- identifiers to use when a national standard has not been adopted [and]
- parameters in the implementation guide that provide options

Encounter data submitted to the Michigan Department of Community Health (MDCH) will be handled using the 837 transaction Provider-to-Payer-to-Payer Coordination of Benefits (COB) data model. Follow the implementation guide for COB reporting guidelines.

(The implementation guide can be found at http://www.wpc-edi.com/hipaa/hipaa_40.asp. HHS guidance on data clarifications can be found at http://aspe.os.dhhs.gov/admnsimp/q0321.htm.)

NOTE: ***Page references*** from the Implementation Guides refer to the **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Dental Claim, ASC X12N 837 (004010X097)** ("Version 4010"), unless noted with an asterisk (*), as referring to the Addenda Implementation Guides ("Version 4010A1), **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Dental Claim Addenda, ASC X12N 837 (004010X097A1)**.

Page	Loop	Segment	Data Element	Comments
53		ST – Transaction Set Header		MDCH accepts a maximum of 5,000 CLM segments in a single transaction (ST–SE), as recommended by the HIPAA-mandated implementation guide. Submission with greater than 5,000 CLM segments in a single transaction (ST-SE) will be rejected.
56		BHT – (Header) Beginning of Hierarchical Transaction	BHT06– Transaction Type Code	Use “RP” – Reporting.
11*		REF – (Header) Transmission Type Identification	REF02 – Transmission Type Code	Use “004010X097A1” if using the October 2002 Addenda Implementation Guide.
61	1000A – Submitter Name	NM1– Submitter Name	NM109 – Submitter Identifier	Use the 4-character billing agent ID assigned by MDCH. This value should match GS02 (Application Sender’s Code).
67	1000B – Receiver Name	NM1 – Receiver Name	NM109 – Receiver Primary Identifier	Use “D00111” for MDCH.
69	2000A – Billing/Pay-to Provider Hierarchical Level	HL – Hierarchical Level	HL01 – Hierarchical ID Number	HL01 must begin with “1” and be incremented by one each time and HL is used in the transaction. Only numeric values are allowed in HL01.
78	2010AA – Billing Provider Name	NM1 – Billing Provider Name	NM108 – Identification Code Qualifier	Use “24” (EIN) or “34” (SSN).
78	2010AA – Billing Provider Name	NM1 – Billing Provider Name	NM109 – Billing Provider Identifier	Use the EIN or SSN value assigned to the provider ID identified in Loop 2010AA REF02 (Billing Provider Additional Identifier).
84	2010AA – Billing Provider Name	REF – Billing Provider Secondary Identification	REF01 – Reference Identification Qualifier	Use “1D” (Medicaid Provider Number); if the provider is not a Medicaid provider, then use “0B” (State License Number).
84	2010AA – Billing Provider Name	REF – Billing Provider Secondary Identification	REF02 – Billing Provider Secondary Identification Number	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by 7-digit assigned ID); if the provider is not a Medicaid provider, use their state license number.

*Page numbers with asterisk refer to the Addenda (Version 4010A1); other page numbers refer to the original Implementation Guide (Version 4010).

Page	Loop	Segment	Data Element	Comments
99	2000B – Subscriber Hierarchical Level	SBR – Subscriber Information	SBR01 – Payer Responsibility Sequence Number Code	To identify MDCH's level of responsibility, use "S" if the capitated dental plan is the only payer (that is, patient has no other insurance), "T" if there are any other payers.
100	2000B – Subscriber Hierarchical Level	SBR – Subscriber Information	SBR04 – Insured Group Name	Use "MICHILD" for children enrolled in the MIChild Program.
101	2000B – Subscriber Hierarchical Level	SBR – Subscriber Information	SBR09 – Claim Filing Indicator Code	Use "MC" (Medicaid) for Michigan Medicaid, "OF" (Other Federal) for MIChild or CSHCS (Title V). If beneficiary qualifies for more than one program, or other MDCH program not listed, use "MC" (Medicaid).
105	2010BA – Subscriber Name	NM1 – Subscriber Name	NM108 – Identification Code Qualifier	Use "MI" (Member Identification Number).
106	2010BA – Subscriber Name	NM1 – Subscriber Name	NM109 – Subscriber Primary Identifier	Use the patient's 8-digit beneficiary ID number assigned by MDCH. For MIChild enrollees use the 8-digit Client Identification Number (CIN) assigned by the enrollment broker.
113	2010BA – Subscriber Name	REF – Subscriber Secondary Identification	REF01 – Reference Identification Qualifier	Use "SY" (Social Security Number).
114	2010BA – Subscriber Name	REF – Subscriber Secondary Identification	REF02 – Subscriber Supplemental Identifier	Report the beneficiary's Social Security Number.
118	2010BB – Payer Name	NM1– Payer Name	NM108 – Identification Code Qualifier	Use "PI" (Payor Identification).
118	2010BB – Payer Name	NM1– Payer Name	NM109 – Payer Identifier	Use "D00111" for MDCH.
132	2000C – Patient Hierarchical Level			MDCH business rules require that the patient is always the subscriber. Therefore, MDCH does not expect health plans to submit any Loop 2000C (Patient Hierarchical Level) in a transaction set. Transaction sets that contain Loop 2000C (Patient Hierarchical Level) information will be rejected.

Page	Loop	Segment	Data Element	Comments
149	2300 – Claim Information	CLM – Claim Information		Note that the HIPAA-mandated implementation guide allows a maximum of 100 repetitions of the 2300 Claim Information loop within each Loop 2000B (Subscriber Hierarchical Level). Transaction sets that do not associate Loop 2300 Claim Information with Loop 2000B (Subscriber Hierarchical Level) will be rejected.
151	2300 – Claim Information	CLM – Claim Information	CLM02 – Total Claim Charge Amount	Report the total of all service line amounts reported in Loop 2400 SV302 (Line Item Charge Amount).
151	2300 – Claim Information	CLM – Claim Information	CLM05-1 – Facility Code Value	Place of service codes are defined by the Center for Medicare and Medicaid Services. These codes can be obtained at cms.hhs.gov/state/poshome.asp
151	2300 – Claim Information	CLM – Claim Information	CLM05-3 – Claim Frequency Type Code	Use “1” on original encounter submissions; use “7” for encounter replacement, and use “8” for encounter void/cancel. For both “7” and “8”, include the original health plan assigned Encounter Reference Number (ERN), as indicated in Loop 2330B REF02, (Original Reference Number).
186	2300 – Claim Information	NTE – Claim Note	NTE01 – Note Reference Code	Use “ADD” (Additional Information).
186	2300 – Claim Information	NTE – Claim Note	NTE02 – Claim Note Text	Provide free-text remarks, if needed.
197	2310B – Rendering Provider Name	NM1 – Rendering Provider Name	NM108 – Identification Code Qualifier	Use “24” (EIN) or “34” (SSN).
197	2310B – Rendering Provider Name	NM1 – Rendering Provider Name	NM109 – Rendering Provider Identifier	For Medicaid Providers use the EIN or SSN value assigned to the provider ID reported in Loop 2310B REF02 (Rendering Provider Secondary Identifier).
201	2310B – Rendering Provider Name	REF – Rendering Provider Secondary Identification	REF01 – Reference Identification Qualifier	Use “1D” (Medicaid Provider Number); if the provider is not a Medicaid provider, then use “0B” (State License Number).
202	2310B – Rendering Provider Name	REF – Rendering Provider Secondary Identification	REF02 – Rendering Provider Secondary Identifier	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by 7-digit assigned ID); if the provider is not a Medicaid provider, use their state license number.
209	2320 – Other Subscriber Information	SBR – Subscriber Information		This loop will be used once for the capitated dental plan and once for each other payer.

Page	Loop	Segment	Data Element	Comments
210	2320 – Other Subscriber Information	SBR – Subscriber Information	SBR01 – Payer Responsibility Sequence Number Code	If the patient has Medicare or other insurance, report that coverage with code "P" or "S", as appropriate, and the capitated dental plan coverage with code "S" or "T", as appropriate. If the patient does not have other insurance, report the capitated dental plan coverage with code "P".
210	2320 – Other Subscriber Information	SBR – Subscriber Information	SBR02 – Individual Relationship Code	The code carried in this element is the patient's relationship to the person who is insured. For example, if a child with Medicaid also has coverage under the father's insurance, use code "19" (Child).
210	2320 – Other Subscriber Information	SBR – Subscriber Information	SBR03 – Insured Group or Policy Number	Use the subscriber's group number (assigned by the other payer), not the number that uniquely identifies the subscriber. For example, group numbers assigned by BCBSM are usually 5 digits.
220	2320 – Other Subscriber Information	AMT – Coordination of Benefits (COB) Payer Paid Amount	AMT02 – Payer Paid Amount	Report the total of all service line amounts reported in Loop 2430 SVD02 (Service Level Paid Amount). A value of zero "0" may be reported.
222	2320 – Other Subscriber Information	AMT – Coordination of Benefits (COB) Allowed Amount	AMT02 – Allowed Amount	Report the total of all service line approved amounts reported in Loop 2400 AMT02 (Service Level Approved Amount).
232	2330A – Other Subscriber Name	NM1 – Other Subscriber Name	NM103, NM104, NM105, NM107 – Other Insured Last Name, First Name, Middle Name, Suffix	Use the name of the subscriber as it appears on the files of the capitated dental plan or other payer.
233	2330A – Other Subscriber Name	NM1 – Other Subscriber Name	NM108 – Identification Code Qualifier	Use "MI" (Member Identification Number).
233	2330A – Other Subscriber Name	NM1 – Other Subscriber Name	NM109 – Other Insured Identifier	Use the unique member number assigned to the subscriber by the capitated dental plan or other payer indicated in loop 2330B. For example, member numbers assigned by BCBSM are usually 3 letters followed by 9 digits.
238	2330A – Other Subscriber Name	REF – Other Subscriber Secondary Identification	REF01 – Reference Identification Qualifier	Do not use "1W" (Member Identification Number).

Page	Loop	Segment	Data Element	Comments
241	2330B – Other Payer Name	NM1 – Other Payer Name	NM108 – Identification Code Qualifier	Use “PI” (Payor Identification).
241	2330B – Other Payer Name	NM1 – Other Payer Name	NM109 – Other Payer Primary Identifier	For the capitated dental plan, use the 9-digit Payer ID assigned by MDCH, for example, 171234567. For other payers, use the carrier code assigned by MDCH (see MDCH website for listing of carrier codes). For example, if American Dental Network were the Other Payer, the value (carrier code) carried in this element would be “40315005”. For Medicare Part A (United Government Services) use “00452”. For Medicare Part B (Wisconsin Physician Services) use “00953”.
247	2330B – Other Payer Name	REF – Other Payer Secondary Identifier	REF01 – Reference Identification Qualifier	For the capitated dental plan, use “F8” (Original Reference Number).
248	2330B – Other Payer Name	REF – Other Payer Secondary Identifier	REF02 – Other Payer Secondary Identifier	For the capitated dental plan, enter the plan-assigned unique identifier (encounter reference number) for the encounter.
28*	2330B – Other Payer Name	REF – Other Payer Referral Number	REF01 – Reference Identification Qualifier	Use “9F” (Referral Number) or “G1” (Prior Authorization Number).
28*	2330B – Other Payer Name	REF – Other Payer Referral Number	REF02 – Other Payer Prior Authorization or Referral Number	If the capitated plan or other payer pre-authorized services or a referral, enter the authorization number or referral number here. Do not use the Referral Identification segment in the 2300 loop (which is specific to the destination payer, MDCH).
259	2330D – Other Payer Referring Provider	REF – Other Payer Referring Provider Identification	REF01 – Reference Identification Qualifier	Do not use “1D” (Medicaid Provider ID).
263	2330E – Other Payer Rendering Provider	REF – Other Payer Rendering Provider Identification	REF01 – Reference Identification Qualifier	Do not use “1D” (Medicaid Provider ID).
265	2400 – Service Line			The HIPAA implementation guide allows up to 50 repetitions of the 2400 service line loop for each 2300 loop.
268	2400 – Line Counter	SV3 – Dental Services	SV302 – Line Item Charge Amount	MDCH requires the provider’s usual and customary charge or billed amount.

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Page	Loop	Segment	Data Element	Comments
268	2400 – Line Counter	SV3 – Dental Services	SV304 – Oral Cavity Designation	This element is required to report areas of the mouth that are being treated.
270	2400 – Line Counter	SV3 – Dental Service	SV306 – Quantity	MDCH requires a quantity of “1”. Use a separate service line for each dental service.
271	2400 – Line Counter	TOO – Tooth Information		MDCH will only process one repeat of Loop 2400 TOO (Tooth Information) per service line. Any additional repeats may be ignored.
273	2400 – Line Counter	DTP – Date - Service	DTP03 – Service Date	MDCH expects service date on every service line.
287	2400 – Line Counter	AMT – Approved Amount	AMT02 – Approved Amount	MDCH expects the dental plan’s fee screen amount for the service(s) reported. A value of zero “0” may be reported.
301	2430 – Line Adjudication Information			MDCH expects this loop to be populated for each payer identified in Loop 2320 (Other Subscriber Information).
302	2430 – Line Adjudication Information	SVD – Service Line Adjudication	SVD02 – Service Line Paid Amount	MDCH expects the amount the dental health plan paid the provider for the service(s) reported. A value of zero “0” may be reported.
305	2430 – Line Adjudication Information	CAS – Claims Adjustment		MDCH expects claim adjustment information when the value reported in Loop 2400 SVD02 (Service Line Paid Amount) is not equal to the value reported in Loop 2400 SV302 (Service Line Charge Amount). MDCH expects dental health plans to use the HIPAA-mandated Claim Adjustment Reason Codes to report the reason(s) for the difference.